Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ACCESS MEDIQUIP, LLC
6002 ROGERDALE RD SUITE 300
HOUSTON TX 77072

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
FACILITY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-0223-01

MFDR Date Received
SEPTEMBER 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Servcies: "received verbal authorization that we could bill implants separately from facility on 11/12/09"

Amount in Dispute: $6,202.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider has used the CPT Code 'L9900 – ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS 'L' CODE' in all its billing. The original review of the bill on December 29, 2009, indicates that the bill was denied for several reasons: 197 – Precertification/authorization absent 856-105 – Claims/service lacks info which is needed to adjudication reimbursement withheld as service does not meet criteria of CPT Code description 900-35 [sic] Payment Denied/Reduced for Absence of Precertification/Authorization A reconsideration request was submitted on February 8, 2010. That bill was denied as follows: 181 Procedure code invalid for this date of service 991-001 Invalid procedure code for this date of service – resubmit with correct code. A third review occurred on May 26, 2010. The bill was denied as follows: 181 Procedure code invalid for this date of service 197 Precertification/authorization absent 900-35 [sic] Payment Denied Reduced for Absence of Precertification/Authorization 991-001 Invalid procedure code for this date of service – resubmit with correct code. Finally, a fourth review occurred on August 12, 2010 with denied for these same reasons. Although Provider has submitted its bill 4 times, it has never corrected the L9900 code. Carrier asserts that until the bill is corrected, no reimbursement is owed. Providers DWC-60 is also incomplete as it has failed to include the MAR value for its charged implantable items. The invoiced total was $1894.59. This appears to be an outpatient surgical procedure subject to reimbursement under 28 TAC 134.403. The MAR would be the invoiced amount plus the 10% maximum add0on under 28 TAC 134.403(g) for a total of $2084.05."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 748711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 12, 2009	HCPCS Code L9900	$6,202.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 181 – Procedure code was invalid on the date of service.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 197 – Precertification/authorization absent.
   - 900-035 – Payment denied/reduced for absence of precertification/authorization.
   - 901 – Reconsideration no additional payment. Original payment decision is being maintained. Upon review, it was determined that this claim was process properly.
   - 991-001 – Invalid procedure code for this date of service. Resubmit with correct code.

Findings

1. According to the Table of Disputed Service the disputed service is HCPCS Code L9900 – Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code. The insurance carrier denied the services using denial codes 181 – "Procedure code was invalid on the date of service" and 991-001 – "Invalid procedure code for this date of service. Resubmit with correct code." According to the HCPCS 2009 Medicare's National Level II Codes this is a valid HCPCS code. The health care provider states in part that, "…miscellaneous code L9900 which represents a hex wrench, implantable INS extension and O.R. cable used during the patient's procedure at Covenant SurgiCenter. This miscellaneous HCPCS code is the only code that can be utilized for the device because a more specific HCPCS code has not been assigned by the American Medical Association." Therefore, the denial is not supported.

   The insurance carrier also denied the service using denial code 197 – "Precertification/authorization absent" and 900-035 – "Payment denied/reduced for absence of precertification/authorization." The health care provider states in their appeal letter to the insurance carrier dated June 21, 2010 that "…on 11/12/2009 our Pre-certification Specialist, Lucy Conley spoke with Marsha, Adjuster who informed us verbally that the device supplied during the procedure rendered on the date of service above was authorized and would be compensated." The requestor has submitted a preauthorization approval from UniMed Direct dated November 22, 2009, UMD ID: 967652 supporting that the request for spinal cord stimulator revision was approved; therefore, the denial is not supported.
2. According to the American Medical Association's HCPCS 2009 Medicare's National Level II Codes, HCPCS Code L9900 is a non-valued code and carries a OPPS status indication code of "N – Items and Services Packaged into APC Rates."
3. According to the American Medical Association's HCPCS 2009 Medicare's National Level II Codes, HCPCS Code L9900 is a non-valued code. Therefore, this dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position

statement of the disputed issue(s) that shall include . . . how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).

6. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include . . . how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
7. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "received verbal authorization that we could bill implants separately from facility on 11/12/09."
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 18, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.